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Partnerships and Coalitions for Community-Based Research

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WHAT HAVE SEVERAL DECADES OF HEALTH EDUCATION, PROMOTION, and engagement with community and academic *partners* taught us about community-based research in public health? We know that some lessons derive from specific studies,^{1,2} others from reviews of international research literature,^{3,4} and still others from guides that help practitioners apply their apparent lessons.⁵ This commentary blends the findings of these various studies, reviews, and guides with general principles and guidelines that have emerged from our combined experience and observations in academic, foundation, federal, state, and local situations in the United States, Canada, Australia, and other countries.

Our comments center on community-based partnerships, coalitions, and infrastructure building, but we emphasize that horizontal community coalitions and partnerships must be based on strong vertical relationships between local entities and their state and national counterparts or headquarter organizations. We assume that university-based researchers are often, but not necessarily or always, part of community-based partnership.

In order to answer our first question, we pose additional questions: Why is some partnering essential to community-based research? How much partnering is needed to facilitate the research, community planning, and execution of programs? What are the principles and components of good community partnerships, and how do they fit with the principles of participatory research and the particular demands of academic-community partnerships? What are some cautions for partnerships that become large coalitions? Finally, what lessons have the large community trials in chronic disease prevention taught us?

CONCEPTS AND DEFINITIONS

We use the term *community* to refer generally to localities, but also to groups that have a common interest or cause even if they do not share a common location. Communities form mutual trust based on openness and equal opportunity for all their members, and they hold assumptions

about interdependency based on reciprocity. Community is the foundation for relationships built between and among organizations and individuals. These considerations apply as much to community researchers⁶ and centralized state and national agencies⁷ as to other participants in community life. Academics and state or federal officials need to build trust with their local collaborators as much as community collaborators do with each other.

The shared perception of common place, interest, or cause also helps define community.⁸ Community based research requires active partnerships between those who share a sense of community and researchers who may or may not be members of that community. Research partnerships cannot be simply “paper” partnerships. Because the community based research in planning, implementing, and evaluating programs or services is the product of these partnerships, it requires a truly participatory form of research.⁹

Community partners refers to the coming together of volunteers, agencies, or organizations. These may include local government offices, voluntary agencies, local hospitals, community health centers, self-help groups, and universities. Other partners for community based research include networks (such as local interagency councils), educators, healthcare providers, recreation groups, and other sectors that have a stake in the development of community health action. Partners may also include the private sector, foundations (the *independent sector*), and others who can contribute to public health through their special relationships with their constituencies, customers, clients, employees, or members. These could include, for example, a charity fund providing start-up financing to a voluntary health organization that has partnered with a local church to insure access for hypertension screening to the particular population served by that church.

WHY PARTNERSHIPS ARE ESSENTIAL

Partnerships and coalitions are necessary in developing prevention and health promotion programs or research today because no one agency has the resources, access, and trust relationships to address the wide range of community determinants of public health problems. Current chronic diseases involve a much wider array of lifestyle and social circumstances bearing on the cause and course of disease than did most of the communicable diseases of past public health efforts. Grants to communities and universities for community based

research are insufficient in amount to enable any single state or local agency on its own to address the complex determinants or influences on most population health problems. The limited resources of any one agency combined with the complexity of emerging health issues are further compounded by the limited mandate of any one agency to deal with the entire scope of that complexity. Also, each agency has a limited reach across the population because it serves a particular constituency, membership, or clientele. As agents of change, each organization has limited credibility among varied population groups regarding the myriad aspects of that complexity.

Shared commitment and planning to ensure the resources, mandate, reach, and credibility of an effort do contribute to the sustainability of community health programs.¹⁰ If dependent on any one organization in the long term, programs are not sustained because every organization, at times, is pulled in other directions. Having more than one organization committed to a community health or development effort gives greater assurance that when one organization's efforts are temporarily or permanently redirected elsewhere, the others can continue to work on the coalition issue at hand.

Partnerships also are needed for community based research as a result of the limited perspective that any one profession, discipline, or organization has on people's actual experiences in dealing with the lifestyle aspects of health. Within a community, for example, most age, ethnic, socioeconomic, and residential groups have different life experiences related to smoking, eating, physical activity, and other aspects of lifestyle in regard to health. Researchers and health professionals are particularly skilled in measuring the objective aspects of health issues with their validated, “objective” instruments. But they need the help of others, particularly from lay people with the risk factor or condition or who have family members with the condition, to obtain an adequate understanding of the subjective aspects of the issue, such as quality of life. In the final analysis, no matter what researchers do to reduce objective manifestations of the health problem to measurable indicators, sufferers tend to be most concerned about their quality of life in evaluating whether programs have been helpful to them.¹¹ Asthma sufferers, for example, might have (medically defined) less severe attacks as a result of public health measures to reduce exposure to some irritants, but they will respond most to improvements in their mobility and ability to carry out normal daily activities.

The emerging understanding in the fields of health promotion and disease prevention of the importance of employing an ecological approach to these complex chronic diseases also points to the importance of community-based research partnerships.¹² An ecological approach recognizes the individual as a microcosm within the family, the extended family and friends, the organizational relationships that surround the individual and family, and the broader environmental cultural and societal forces that surround the organizational relationships. This layering of relationships and organizational levels, like the layering of the vertical relationships among local, state, national, and international organizations, ultimately affects people's understanding of health practices, changes in health practices and conditions, and their willingness and ability to do something about them. For example, smokers who see their addiction in only personal terms feel guilty and helpless, but when seen in the larger context of peer relationships and work environment, they are better able to develop effective strategies to quit.

Other benefits of partnerships that have been catalogued by Butterfoss and others¹³ include:

- A partnership or coalition allows some individuals relative freedom from the confines of their individual organizations and enables them to explore new situations. If confined to their own organizations, professionals often develop "tunnel vision." By partnering with others, engaging in a common enterprise beyond their own organizations, these professionals may experience greater freedom to explore new possibilities and to innovate.
- A partnership enables individuals in member organizations to become involved in issues without burdening them or their organizations with sole responsibility for these issues.
- A partnership can generate greater public awareness and support when the public sees the common commitment of several organizations. When they realize that several partners are working together on the issue, people and their elected representatives can appreciate that an issue has a bigger constituency than that of a single agency.
- A partnership can create a critical mass for action, where one organization on its own may have felt powerless or without sufficient resources to make a difference.
- A partnership can minimize duplication of effort and resources, and act as a strategic vehicle to mobilize and leverage resources.

LESSONS FROM LARGE COMMUNITY TRIALS

What has the very expensive investment by the National Institutes of Health in large-scale community trials—the Stanford Three-Community Project,¹⁴ the Stanford Five-City Project,¹⁵ the Minnesota Heart Health Program,¹⁶ the Pawtucket Heart Health Program,¹⁷ and the COMMIT trials¹⁸—contributed in recent years to the understanding of community based partnerships? These community trials in cancer, heart disease, and tobacco reduction, in particular, were large social experiments to assess whether comprehensive, multi-level interventions produce significant benefits in population disease prevention and health promotion.

In some ways, these trials have produced disappointing results. While they did produce some significant changes, such as reductions in smoking, their net gains were less impressive in comparison to the progress made at the same time in matched communities that had not received the experimental interventions, such as new school and worksite health education programs.¹⁹ Public health experts have tried to understand how much the changes in smoking resulted from these specific community interventions and organizational strategies, and how much the changes were simply the product of global or national or statewide trends and programs.

In looking critically at what those community trials did and did not do, we must first ask whether the community trials truly qualified as community based. Did they include grass-roots planning and implementation of change at the local level? The trials were conducted in communities, but they were conceived in university departments and described in grant proposals submitted to federal agencies for funding. These trials, then, were more a partnership between federal agencies and researchers at the university (that identified the questions to be asked and the methods to be used), than partnerships between researchers and communities. Thus, the trials were applied in the communities, but not truly community based.

Next, we ask if these trials added any community-focused social science to the person-focused behavioral science models of previous work? A majority of social and behavioral science co-investigators on most of the major projects came from the fields of psychology or social psychology. Consequently, psychologists and their psychological models tended to dominate the thinking about applications of the social and behavioral sciences to the community trials.

The trials thus involved behavioral change approaches that were more individual than institutional

in their intervention focus, more educational and skill oriented, for example, than policy or environmental support oriented. They were not sufficiently ecological to be able to intervene at several levels of organization for community change,²⁰ nor sufficiently collaborative for compelling community assessment and action.²¹ Most of the large trials gave little emphasis to communities as systems with multiple, interdependent sectors linking individuals, families, small groups, and organizations into a cohesive whole.²² Thus, the trials gave less attention to organizational change or broad community change in norms, environments, economics, and policies than would have been optimal to achieve more significant results compared with the secular trends that were occurring in neighboring comparison communities.

Effects of broad secular trends.

How do we account for the broader secular trends (statewide, national, and global trends occurring at the same time as the community trials) that were so pervasive during this time? These trials were conducted mostly in the 1980s and early 1990s, a period in which there was already a great deal of international press coverage of the risk factors associated with chronic diseases. Communities and individuals were

realizing the need to change their behaviors in diet, smoking, and exercise. Behavior change was occurring on a massive scale. For example, the downturn in smoking that began in 1965 in the United States led to a 50% drop in per capita consumption of cigarettes over the next 30 years. Low-fat alternatives to whole milk and red meats also gained substantial market shares in food purchasing in the US and Canada as a result of national nutrition campaigns. Thus, a massive secular trend was already developing in North America.

Communities throughout the US and Canada were beginning to pass local ordinances for smoke-free workplaces, restaurants, and other environments during the 1980s. They were setting aside bicycle paths on their roads. They sponsored self-help, self-care, and self-man-

agement groups in growing numbers. Communities used as comparison populations for the big community trials were taking many of the same health-promoting actions that were recommended by the university-based investigators and their local collaborators in the trial communities. Some comparison communities took their cues directly from the publicity surrounding the trial communities, and others indirectly, through professional literature or state health department staffs who were influenced by either the experimental initiatives or the scientific literature on which they were based.

People in other developed countries were now recognizing that by mid century, chronic diseases had overtaken communicable diseases as the leading causes of death. Individuals in these countries began in the mid-1960s to curtail their smoking, and soon after to moderate their fat intake and increase their physical activity.

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Trial durations. Did these trials continue for enough time? Did the evaluations allow sufficient follow-up time for the changes sought to occur? Time is an essential ingredient in a complex world of inter-organizational relationships attempting to influence community norms that affect individual behavior and, in the long run,

health outcomes.²³ Such changes do not occur in a matter of days, weeks, or months. It is often five to eight years before changes in policies and social norms, the long-term goals of community based disease prevention and health promotion, are met. For some chronic disease mortality results, such as cancer, the lag time between behavior change and impact on mortality may be as long as 20 to 30 years.

Should population models be changed? These considerations lead us to question whether some other population aggregate would serve as well, if not better, than local geopolitical communities as the focus of intervention and the units for measuring change. Should the level of intervention be shifted more aggressively to states or

provinces, or to individual institutions, such as schools and worksites? Because the localities that are defined as geopolitical entities in each state or region vary widely in their capacity and indigenous infrastructures, their ability to undertake a given community-based study or program will vary accordingly. Although two communities may seem to have equal resources to undertake a cooperative program and achieve the desired outcomes, one community may achieve very different outcomes from the other as a result of its mutual trust, traditions of collaboration, and ability of its residents to work together. These aspects of community cohesion and capacity reflect the idea of social capital. They underpin much of what we understand about organizational partnerships in differentiating the capacities of different communities to act effectively (MW Kreuter, personal communication regarding research in progress, 2000).

CAUTION IN ASSESSING LARGE COMMUNITY TRIALS

The lesson here is to exercise some caution concerning the limited results of these large community trials, in part because of the limitations themselves, and in part because they predated the application of concepts such as social capital in the measurement of community

capacity and readiness for change. The trials captured a series of snapshots in the early phases of slowly unfolding community and population changes, such as institutional changes, policy initiatives, and changes in social norms. While comparison communities might not achieve these desired outcomes during early phases of the trials, they catch up quickly as they imitate the experimental communities or receive guidance a little later from the same scientific literature. The experimental communities appear to have achieved little in comparison to their controls when measures of changes are taken 2–5 years following the first interventions.²⁴

This suggests that community-based research should not defend community interventions solely on the basis of the results that have been published from these large

community trials. Much more is available in the literature on community development, community organization, community and multicultural program planning and implementation, public health practice, health education, inter-organizational relationships, and other subspecialties of social science, public health, and community planning. From this cumulative body of literature we find decades' worth of wisdom, and evidence for the efficacy of organizational and policy changes that can be brought about through increased public awareness, community mobilization, coalition-building, advocacy, political negotiation, and good program management and evaluation. Whether this wisdom was effectively applied in the large

community health trials, and whether their effects were effectively measured with appropriate experimental designs, are subjects of much reflection in recent public health literature. Some of the debate centers on finding the right balance between local initiatives and broader statewide or national policies and support for local effort.^{25,26}

MOTIVATIONS FOR PARTNERING

The central questions for this paper concern the advantages and motives for partnering. Two or more organizations partner when

they identify mutual benefits from interacting, or when at least one of them is motivated to establish a relationship, and is powerful enough to compel the other(s) to interact. If a partnership is to gain resources, or to try to combine resources, then potential partners must consider some loss of control over their own resources by each partner. In this context, the relative size of the organizations involved is an important issue. The resources each brings to the partnership will predict in many ways the roles that each organization, or the individuals representing it, will play and the degree of control each may expect to exert. Defections from coalitions, not surprisingly, are often by larger or richer organizations that find it difficult to justify giving up or sharing much of their autonomy and control. In a national coalition on low-fat eating,²⁷ for example,

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the American Heart Association was the first to withdraw because it could not justify having one vote at the same table as the many smaller organizations that were also each accorded one vote.

If the main motivation for partnering is the lure of external resources (grants offered by foundations or states to collaborative efforts, for example), the partnering organizations need to replace that motivation with something more closely related to the values of their community. They will need something more intrinsic to the issues that they are addressing, because the resources will quickly be allocated and depleted. When external resources are allocated to the partners expected to carry out community research or program functions, the coalition and external funders usually assume that the organizations will contribute at least in kind. Thus, no one organization may enjoy enough external benefit to sustain its motivation to participate. Each participating organization must have deeper motives, in addition to the new marginal resources, to sustain its participation.

PRINCIPLES OF GOOD COMMUNITY PARTNERSHIPS

Some inherent limitations arise with the tendency to increase the number of partners and to make coalitions more complex. According to C. N. Parkinson's third "law," expansion means complexity and complexity means decay.²⁸ This indicates the importance of the degree to which coalitions create unnecessary complexity, which can jeopardize their success. A growing coalition, for example, can reach a point where it spends more time on governance and resolving conflicting organizational viewpoints than it spends on program development and implementation.

Parkinson's fourth law was that the number of people in any working group tends to increase regardless of the amount of work to be done. Its corollary is that officials want to multiply subordinates, not rivals. His fifth law recognized if there is a way to delay an important decision, the good bureaucracy, public or private, will find it. Each of these laws holds some caution for the overzealous coalition builder who needs to be reminded of these "natural" tendencies in bureaucratic behavior and the unintended consequences they sometimes yield.

Some principles²⁹ of successful partnerships follow from the above:

- Partners must agree on missions, goals, and outcomes.
- Partners should have mutual trust, respect, and commitment.

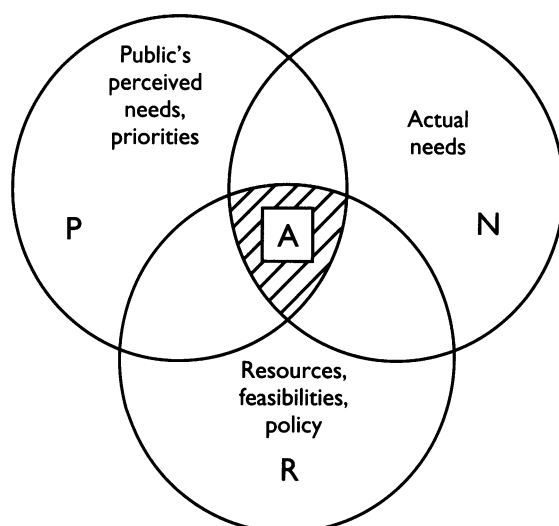
- Partnerships need to build on identified strengths and assets. Instead of approaching a community based partnership by itemizing all of the problems that the community faces, it is better to focus on the strengths and assets of the partners and the community in developing plans.³⁰
- Good partnerships should have clear communication among partners and transparency in the decision making process. They must make clear the language to be used, and if it is a medically dominated partnership they need to ensure that those who are not medically trained can understand the complexity of that particular language.
- Partnerships evolve using feedback to, among, and from all partners.
- Roles, norms, and processes for the partnerships should evolve from the input and agreement of all partners. Partnerships need a governance structure that establishes a common understanding of how to proceed.
- Successful partnerships have relationships with local leaders and funding agencies. Health agencies cannot focus only on health, but must work with political leaders and financial sponsors who have different, and usually broader, visions of the community's quality of life. Health agencies must show how their issue relates to those broader perspectives, such as economic and recreational concerns, in addition to health.
- Effective partnerships use existing structures, such as schools and worksites, to incorporate solutions into their mission. They may create new ones, if necessary, but only after demonstrating that the community's existing structures are inadequate to the task.

Successful partnerships begin with principles of community self-determination and ownership of problems, which are essential before building consensus on priorities, resources, and specific actions. Successful partnerships focus on commonplace, easily identifiable, solvable, and publicly owned problems that citizens feel competent in resolving. The public health field needs to build a collective sense of efficacy or self-confidence in community groups³¹ as much as the personal health care field has demonstrated the value of enabling self-efficacy in individuals.³²

ALIGNING PERSPECTIVES OF THE PARTNERS

As researchers approach any community, they must address three worldviews, as shown in Figure 1. Two of these include the public's *perceived* needs and priorities

Figure 1. Reconciling differences among public's perception of needs, health sector's assessments, and political assessments



SOURCE: Reference 11, p. 58

and its *actual* needs. Actual needs are those measured by health professionals or scientists with their (sometimes incomplete, if not imprecise) instruments or surveys. The third worldview is that of the politicians, legislators, or city council members who make decisions about allocation of resources based on what is feasible and available, and the competing pressures they perceive regarding how to allocate these resources.

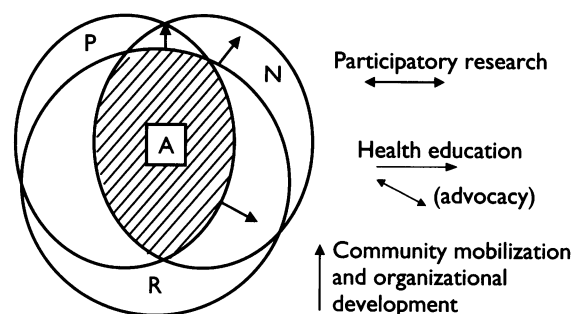
It is particularly in the area (A) where the three views overlap that community-based partners have the greatest potential for action. Without public support, the overlap of professional (actual needs) and legislator views will not have the political support needed for passage or enforcement. Without both of the other two areas of overlap, the public's perception of its needs often will fail to convince the professional for lack of measurement, or the politician for lack of weight against competing priorities for allocations. When all three world views overlap, political, professional and managerial perspectives merge to form a winning coalition.

Communities can seek to enlarge Area A or align the three views by bringing them closer together, as shown in Figure 2. Community based research partners can bring circle P, the public's view, further into alignment with circle N, professional understanding of problems (actual

needs), through public health education and other means of disseminating scientific knowledge. The partners also can align these two spheres of perception by bringing circle N closer to circle P through a more participatory style of research. Community based research partners obtain assistance in aligning both of these spheres by (a) assessing needs in the community, and (b) evaluating community programs in collaboration with members of the community who perceive issues more from the public's perspective than from the professional perspective.³³ Finally, these research partners can raise circle R to enlarge action area A through community mobilization and organizational development strategies. These strategies and their associated political processes can help move the perceptions of politicians into closer alignment with the public's perceptions. Through media advocacy, for example, community based researchers can employ what the tobacco control movement, Mothers Against Drunk Driving (MADD), and other advocacy groups have learned. Community partners, too, can garner media exposure and arouse public awareness, interest, and actions to bring their perceptions to bear on the politicians' understanding of what their constituents consider important. One of the most important lessons advocacy groups have learned, for example, is to use news events strategically—for free, and for more far-reaching media coverage—rather than investing exclusively in public service announcements or paid advertising.

The combination of all elements represented by the three overlapping circles is essential to successful community partnerships because their joint enlargement of the shaded area produces common concerns for information, research, and action (see Figure 2).

Figure 2. Strategies to reconcile perceived and actual needs and resources



SOURCE: Reference 11, p. 58

NEED TO LIMIT SIZE OF COALITIONS

Groups enter partnerships to gain maximum power while expending minimum resources. Once a partnership receives or consolidates its power, rewards are usually distributed among allies in proportion to the amount of power and resources each originally brought to the partnership. An excess of members or resources in a community partnership may produce a disappointing payoff as the rewards may be spread too thinly to warrant the effort expended. Some foundation grantmakers have found that when they try to overcome the limitations of small grants to community agencies by giving large grants to coalitions, the coalitions are unaccustomed to working with such sums and become overwhelmed by their fiscal responsibilities, to the detriment of their programs.³⁴

Agreement on common goals increases in difficulty in proportion to the number of partners. Adding more organizations does not result automatically in an additive effect on power, as the power becomes diffused and the complexity compounded with too many partners. More organizations in a partnership multiply the effect on complexity because the permutations of relationships increase by more than one with each new partner.³⁵ Four organizations have greater than one degree more of complications and lines of communication than do three organizations. Complexity is not inherently a bad thing, but community partners need to think about the trade-off between potentially increased power with greater numbers and the complexities added to governance and management that are associated with increased size of coalitions. Large partnerships warrant the term *coalition* to convey their greater magnitude and complexity, useful in the early phases of consensus building and goal setting for the community, but increasingly difficult to manage in the implementation phases.

To overcome some of the difficulties associated with greater size, large coalitions can turn to the Noah's Ark principal of partnering: at the point of implementation, go forth two-by-two.³⁶ This principle suggests that commu-

nity research partners use coalitions for what they are best at accomplishing: achieving a common vision, agreeing on a common goal, and perhaps even finding agreement on some specific objectives and strategies. From that point forward, coalitions should assign pairs of agencies and organizations to the functions that support the broad goals on which all partners agree. Those pairs or smaller partnerships should be given the freedom to implement their own or joint programs without the larger coalition's constant involvement. The frequency of meetings of the larger coalitions can then be reduced to quarterly or semi-annual gatherings to mark and celebrate progress, and to adapt the goals, if necessary.

The most important role that coalitions can serve in

the community may be in identifying a vision and broad goals on which all can agree, rather than micro-managing programs. Partnerships are essential for all the reasons outlined in the first part of this article, and community researchers must foster them. As they grow, however, community partners must also guard against the many pitfalls associated with size, complexity, and attempts to run programs by large committees.

PARTICIPATORY RESEARCH

Participatory research seeks to ensure community representation and ownership of the questions to be asked, the methods to be used and, ultimately, the interpretation and application of research results.

Participatory research is a way of bringing into closer alignment the distinct perspectives on health needs of the public, health professionals, scientists, and those who fund or make decisions on health and health-related issues. By engaging the community and its decision makers in their research on needs, for example, researchers and all other parties can contribute to the selection of things to measure, and to the analysis and interpretation of findings. The partnerships enabled by participatory research can yield more balanced collaborations among researchers, communities, and funders than can partnerships among large-scale community trials or large community action coalitions. Rather than involving communities only in implementation and evaluation of health initiatives planned elsewhere, participatory research

seeks to ensure community representation and ownership of the questions to be asked, the methods to be used and, ultimately, the interpretation and application of research results. The emphasis on participation through mutual interest and shared responsibility for local initiatives is a major feature of participatory research.³⁷

In the Study of Participatory Research in Health Promotion for the Royal Society of Canada, we attempted to clarify this issue by providing a working definition and set of guidelines for use by funding agencies that appraise projects proposing or attempting to conduct participatory research.³⁸ Since many disciplines have different understandings of the processes and expectations of participatory research, the discrepant perspectives can result in inappropriate reviews, at least by funding agencies that use conventional scientific criteria as their reviewing standards. The study defined participatory research as "systematic enquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting social change." The guidelines that emerged from this study³⁹ emphasize how traditional ways of conducting health research in communities need to be adapted to meet the basic educational and policy expectations of participatory and community-based research.

Participatory research appeals to communities, non-academic organizations, and lay groups that seek to use research to achieve their action agendas but feel that university led research has not been entirely responsive to their needs.⁴⁰ Linking research, education, and social action, the participatory approach is consistent with the aims and theories that underpin community-based health research and health promotion. A defining feature of participatory research is its blurring of the distinction between researchers and those being researched.⁴¹ This contrasts with scientific research traditions that require treating "subjects" with objectivity. Participatory research breaks down this distinction, aiming for mutual trust and a reciprocal learning process. The key to participatory

research lies not with any given method but, rather, in the attitudes of researchers, which in turn affect how and for whom the research is constructed and conducted.⁴²

Our review and consultations for the Royal Society of Canada suggest that participatory research is particularly suited to the field of disease prevention and health promotion, and holds strong attraction for researchers and practitioners.³⁸ We found it was being used to address a range of specific health issues, such as services after hospital closure, diabetes, and AIDS. These issues lent themselves to participatory research because the population was already concerned about the specific problem, or because the categorical funding sources

matched the categorical problem (for example, diabetes, AIDS). We also found that some early precepts of participatory research (such as emphasis on social action) from work in Latin American,⁴³ African, and Asian countries, were applicable to North American communities to address poverty, limited education, and high prevalence of social and health problems.⁴⁴ Lastly, the impetus for participatory research projects came most often from a professionally trained researcher or health practitioner. This may simply be a phase in the ongoing development of

Participatory research projects usually require complex and time-consuming processes of building relationships, trust, and divisions of responsibilities among partners.

participatory research, indicating the lead that professionals have taken in introducing this approach to communities. An alternate explanation, however, may be that lay community residents do not use this tool on their own initiative because it compromises their need for greater political expediency.

Researchers, community residents, and funding agencies have all felt varying pulls or pushes toward participatory research.⁴⁵ Participants newly skilled in taking control of their lives have become involved in projects in which there may be no predetermined research plan or time schedule, and the intended outcomes for which may be political, economic or social. Each of the potential partners may be invited to contribute resources, skills, volunteer time, or other supports. Without sufficient time

to build trust, often the case with time-limited grant application schedules, this contribution requires a great leap of faith on the part of potential partners. Participatory research projects usually require complex and time-consuming processes of building relationships, trust, and divisions of responsibilities among partners. Without a common language, expectations for the process are difficult to meet. Negotiating what may be unfamiliar terrain for some prevention researchers need not be too difficult, however. The premises that the community has insights about and solutions to a given issue or problem, and that people of the community should play an integral role throughout the iterative process of disease prevention (from knowledge production to social change), has a long history of successful implementation and results.⁷ Examples of recent North American applications are seen especially in Healthy Community projects.^{46,47}

PRACTITIONER PERSPECTIVE ON ACADEMIC-COMMUNITY PARTNERSHIPS

The rationale for community partnerships is particularly compelling for local public health agencies.⁴⁸ In the United States, involvement in coalitions with organizations having similar objectives has been driven by financial considerations of local health agencies. Such pooling efforts are prompted by the shift in agencies' role from provision of personal health services (since the 1966 enactment of Medicaid legislation) back to population-based prevention activities.⁴ Federal agencies that competitively fund local public health agencies, as well as foundations such as WK Kellogg and Robert Wood Johnson that fund national initiatives (for example, the Turning Point Project for community initiatives in substance abuse prevention), have embraced the partnership or coalition model as a requirement both for planning and implementation. Some funding agencies even require that a coalition exist before a grant is awarded.

Public health department involvement in research is not new. A classic trial of water fluoridation, initiated by the New York State Department of Health in 1945, compared the rate of dental caries in two Hudson River communities, one with and one without fluoride in the community water supply.⁴⁹ Documentation of a positive outcome in the intervention community led to widespread implementation of fluoridation. This is an example, however, of community research initiated by the community agency but directed externally. It was not a community partnership or coalition-guided research project in its execution.

By definition, academic-community partnerships in prevention research contain representatives from both academia and practice (for example, the local health department) and this dyad may be a subset of a larger community coalition. The community coalition can be important to the focus and design of the research project as well as to the dissemination of findings. Actual project implementation is generally assigned to practice and academic partners who must deal with design, collection, sampling, and safeguarding confidentiality of the data gathered.

Public health agencies and academic partners working as a pair or as part of a larger coalition have substantial potential advantages over working alone in formulating and implementing preventive research. Each entity brings distinct and complementary knowledge, experience, and insight to the issues to be studied. These partnerships also have advantages in translating the research findings into community action because they combine a broad knowledge of evidence-based practice with context specific knowledge of the population and the history of community interventions in that population.

Community coalitions that include an official health agency have, by extension, a mandate for assessment and assurance of the health of a community. This population outcome-based responsibility calls for prevention research, if only at the levels of systematic surveillance, needs analysis, monitoring, and evaluation. Data sources of local health agencies, supplemented by state and federal information, are extensive for mortality, considerable for communicable disease reporting, but until recently very limited on health behaviors.⁵⁰ A local survey capacity can meet the need for gathering periodic prevalence estimates on sentinel health behaviors.⁵¹ Such a survey capability is greatly enhanced and more likely to be mined for analyses if partnered with an academic institution.

Within the dyad of academic and practice partnerships, the different agendas, capacities, and skills of these two parties may present challenges to the collaboration. Public health agencies are not laboratories. Public health information systems often contain categorical data that have definitions or other reporting conventions with levels of precision and accuracy unsuitable for research. Within the partnership, there can also be disagreement between partners on issues of governance, project design, and benefits to the community.

These obstacles are outweighed by the potential benefits to research that academic partnerships with communities offer. One such advantage is greater community acceptance of research, because of the broad involvement

of various sectors in the research planning and implementation phases. One county health department in central New York, serving a population of less than one-half million, has active academic-practice partnerships in research overseen by specific community coalitions. These coalitions address sexually transmitted disease, infant mortality reduction, cost effectiveness of preventive services for senior citizens, reduction of cardiovascular disease, and reducing health risks of adolescents. Difficulties in implementing research in these areas, which can occur as early as the health problem assessment phase, are minimized by participation and discussion among community stakeholders of the research.

Investments in prevention research associated with academic-practice partnerships may also help answer questions on how best to apply prevention research. That this need exists is supported by the CDC-sponsored US Task Force on the Guide for Community Preventive Services, which recognized that any new guidelines for population-based prevention initiatives generate a secondary list of research questions. Answers are needed for determining how best to disseminate and apply research outcomes.⁵²

Consistent with the preceding review of the literature and our experience with community coalitions, an overriding factor influencing the success of academic-practice partnerships is the nature of the relationship, or the interaction between principals with respect to sharing work and perceived benefits. The three worldviews (see Figures 1 and 2) described above can be harmonized more expeditiously when all parties participate on an understanding of the distribution of work and benefits. The public's, scientist's, and politician's views will overlap when the findings emerge from a collaboration of all three spheres engaged in the project. Research findings do not necessarily, or even generally, determine policy and resource allocation

because the three interested parties too seldom collaborate in the data collection and analysis process. When the interested parties—academics, practitioners, residents, and policy makers—collaborate in data collection, interpretation of research on needs and resources, and on evaluation of programs, their common interest, and therefore the interests of the community, are better served.

CONCLUSION

The many disease prevention and health promotion programs initiated by community partnerships and the growing number of research activities conducted by community-academic partnerships have taught the public health field many valuable lessons about community based research in public health. Such partnerships are often the most efficient way to apply scarce resources to some critical community health problems, while ensuring the sustainability of the programs that result from the research. Although many of the large-scale community trials conducted by researchers in communities have produced disappointing results, they have demonstrated the importance of treating communities as full partners and allowing enough time for change to happen in the complex systems of communities. There are many obstacles to the success of academic-community research partnerships, but these obstacles are outweighed by the many potential benefits of collaborative research, including greater community acceptance of research results and policy proposals.

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